COMMONWEALTH of VIRGINIA

IN COOPERATION WITH THE
STATE DEPARTMENT OF HEALTH

Southside Health District
Brunswick, Halifax and Mecklenburg Counties

DISTRICT OFFICE
Post Office Box 560
Boydton, Virginia 23917
Phone: (804) 738-6815
Fax #: (804) 738-6295

WAIVER

_____ County Health Department Date: _____

Director: _____ Re: _____

From: _____

I recommend that _____ be granted full or partial
(Client's Name) (circle one)

waiver of payments for services given in the _____

clinic. He/she changed from income level _____ to _____ according

to the new CHS-1completed on _____ by _____ .
(Date) (Interviewer)

WAIVER RECOMMENDED BECAUSE:

Reduced Income Level Status _____
Unusual Family or Individual Health Problems _____
Financial Hardships (Documentation attached) _____

REQUEST FOR WAIVER GRANTED: _____ _____
(Signature) (Date)

(If partial waiver, a copy of the payment plan is attached.)

REQUEST FOR WAIVER DENIED: _____ _____
(Signature) (Date)

WAIVER EXPIRES ON _____ WAIVER EXTENDED UNTIL _____
(Date) (Date)

BASED ON NEW FINANCIAL ELIGIBILITY COMPLETED ON _____

COMMENTS/DOCUMENTATION:

_____

_____

_____

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment